THE REPORT OF

THE ANAESTHESIA DRAFTING COMMITTEE

AUGUST, 1979

Gill/committee

Regina, Saskatchewan
August 1979

The Honourable Herman H. Rolfes
Minister of Health
[redacted]

[redacted] of certain recommendations contained in the Report of the Board of Inquiry on Anaesthetic Practices in Saskatchewan.

The Committee's purpose was to review existing hospital bylaws and regulations relating to the practice of anaesthesia and to propose model guidelines, principles and rules and regulations appropriate to hospital size and function.

The Committee held eight meetings and the results of its work are presented in this report. It is the hope of the Committee that its work will contribute to the improved delivery of health care in Saskatchewan.

Respectfully submitted.

H. D. Walker, Ph.D
Chairman

J. [redacted], C.R.C.P.(C)

Gordon M. Wyant, C.D., M.D. F.R.C.P.(C)
F.R.A.R.C.S.
Representing
College of Medicine
University of Saskatchewan

[redacted], M.Sc.N.
Representing
Saskatchewan Health

Murray M. Fraser, M.D., C.M.
F.R.C.S.(C)
Representing
Saskatchewan Medical Association

Royce H. Gill
Royce H. Gill
Representing
Saskatchewan Health-Care Association

Hon. Herman H. Rolfes

August 1979

Sydney J. Parsons, M.S.W., D.H.A.
Representing
Saskatchewan Health-Care Association

Martin S. Boyd, M.B., Ch.B.
Representing
Saskatchewan Medical Care Insurance
Commission

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I. BACKGROUND

On October 29, 1975 the then Minister of Health, the Honourable Walter Smishek authorized the establishment of a Board of Inquiry on Anaesthetic Practices in Saskatchewan, pursuant to the provisions of Section 100 of the Regulations under The Hospital Standards Act. The Board chaired by Mr. D. Trevor Anderson, Associate Dean of the Faculty of Law, University of Manitoba was directed to inquire into the administration of general anaesthesia in hospitals in Saskatchewan, and the supervision thereof, and to recommend reasonable standards for such supervision and administration and to report to the Minister of Health those recommendations and the findings of such inquiry.

The Board of Inquiry submitted its report to the Minister in December 1976. The report contains 53 recommendations directed to the medical profession, hospitals, the College of Medicine, the dental profession, and the Department of Health.

Certain recommendations contained in the report of the Board of Inquiry on Anaesthetic Practices in Saskatchewan suggested the creation of a Drafting Committee to look at anaesthetic guidelines and principles, hospital bylaws, forms and record keeping systems, and regional medical audit systems. Consistent with these recommendations, on June 29, 1977 the Minister announced the creation of an Anaesthetic Drafting Committee to be chaired by Dr. H. D. Walker. Other members of the Committee are Dr. G. M. Wyant, Dr. M. M. Fraser, Mr. A. G. Ayers, Mr. S. J. Parsons, Dr. J. Parker, Mrs. K.G. Crofford Mr. R. H. Gill, Dr. M. A. Gormley, Dr. M. S. Boyd, and Dr. W. Dorsett (until March 29, 1978).

II. PURPOSE

The Committee's purpose was to review existing hospital bylaws and regulations relating to the practice of anaesthesia and to propose model guidelines, principles and rules and regulations appropriate to hospital size and function. More specifically, the Committee's terms of reference, established by the Minister, were as follows:

1. To review existing hospital bylaws, Department of Anaesthesia Rules and Regulations and any other documents that will assist the Committee.

2. To study the Report of the Board of Inquiry on Anaesthetic Practices in order to identify desirable anaesthetic guidelines and principles.

3. To propose model anaesthetic guidelines and principles appropriate to hospital size and function.

4. To propose model Department of Anaesthesia Rules and Regulations appropriate to hospital size and function.

5. To review existing hospital anaesthetic records, forms and record keeping systems.

6. To propose model hospital anaesthetic records, forms and record keeping systems appropriate to hospital size and function.

7. To make recommendations concerning Anaesthetic Technical Assistants (ATAs).

8. To review provisions of The Hospital Standards Act and Regulations under The Hospital Standards Act relating to anaesthesia and to propose possible amendments to the Act and/or Regulations.

9. To propose options with regard to a regional medical audit system.

ACKNOWLEDGEMENTS

The members of the Committee wish to record particularly, their appreciation of the services rendered by its working party, Mr. Paul Rennie and Miss Beverly Goodman for their research, organizational and secretarial talents.

III. RECOMMENDATIONS

The Committee in setting forth its recommendations does not expect individual hospitals to adopt the model rules in their entirety, but suggests that each hospital should study their present rules with the view of having them meet the minimum requirements proposed in the report.

The following are the recommendations of the Anaesthetic Drafting Committee. The background and explanation for each recommendation is contained in the body of the report.

1. That each hospital having an anaesthetic service adopt the "Guidelines for Minimal Standards of Practice of Anaesthesia in the Province of Saskatchewan" as goals which they will strive to achieve.

2. That each hospital having an anaesthetic service examine its rules and regulations for anaesthesia and after study and consideration of the model Rules and Regulations for the Department of Anaesthesia make such changes as are necessary.

3. That each hospital examine its present operating suite safety regulations with reference to the model Fire Safety Regulations to ensure that the hospital's safety regulations are appropriate, kept current (new developments should be included on a regular basis), and enforced.

4. That each hospital having an anaesthetic service adopt, with or without modification, the model Pre-Anaesthetic Assessment, Anaesthetic Record and Recovery Room Record forms. Individualized forms should contain, as a minimum, the information contained in the model forms.

5. That the Minister of Health recommend to the Lieutenant Governor in Council the making of amendments to Regulation 285/74 as proposed.

6. That the College of Physicians and Surgeons of Saskatchewan be invited to develop a regional medical audit program as a pilot project, that all or part of the funds for such a pilot project be provided by the Department of Health, and that the project be evaluated after 3 years.

7. That each hospital using PAS or PAS-QAM be encouraged to use the "optional areas" on the PAS abstract for studies of the anaesthetic service and other clinical and administrative studies related to the Anaesthetic Service.

8. That health record consultants conduct workshops designed to teach health records staff in small hospitals how to assist the medical staff in conducting medical audits.

9. That the Department of Health fund all hospitals which are accredited or are actively seeking accreditation, regardless of size, to participate in Professional Activity Study (PAS) offered by the Commission on Professional and Hospital Activities. These funds should be sufficient to apply to both inpatient and outpatient services.

10. That the College of Physicians and Surgeons periodically review and comment upon the medical audit programs of all hospitals.

11. That the medical audit program undertaken in each hospital address itself to all clinical services, including anaesthesia.

12. That the Board of Inquiry's recommendations concerning the training and employment of Anaesthetic Technical Assistants <u>not</u> be implemented.

13. That each hospital be funded to provide technical support for anaesthetists, such as the servicing, standardization, cleaning, setting up and general maintenance of anaesthetic equipment.

14. That the following approaches be considered as methods of providing an increased number of specialist anaesthetists for the province:

    a) The training in Saskatchewan of additional qualified anaesthetists, through the creation of conditions outlined below which will encourage more medical school graduates to enter the specialty of anaesthesia, and which will encourage present and future specialists to remain in this province:

        i) more attractive remuneration and conditions of practice for anaesthetists;

        ii) increased number of residency positions in anaesthesia without a reduction in other residency programs;

        iii) greater, more positive and earlier exposure of medical students and medical interns to the field of anaesthesia;

        iv) provision of resources and opportunities to allow anaesthetists to spend more time in direct patient care;

        v) greater support for research within the College of Medicine, Department of Anaesthesia, to include salaries, research assistants, facilities and equipment;

        vi) special annual grants to purchase capital equipment for the clinical provision of anaesthesia.

    b) Continued active recruitment and provision of funds by the Department of Health for this recruitment of qualified anaesthetists from outside the province.

15. That each hospital examine and if necessary, revise the form it presently uses for "Consent to Operation and Anaesthesia," to ensure that it directs the patient to the risks and benefits of anaesthesia and that it provides a statement regarding restrictions, if any, on the type of anaesthetic to be used.

16. That the recommendations of the Board of Inquiry on Anaesthetic Practices in Saskatchewan directed to those involved in the provision of the service of anaesthesia in non-hospital facilities, be adopted and actively adhered to.

IV. INTERPRETATION

In this report the expression:

"anaesthetist" means a member of the medical staff of a hospital who administers a general or regional anaesthetic to a patient.

"base hospital" means a general hospital which serves as a district or community hospital for the local population. It provides a wider range of services than a regional hospital and therefore serves as an ultimate referral centre in the province. It also performs a major role in research and education.

"Board of Inquiry" means the Board of Inquiry on Anaesthetic Practices in Saskatchewan established by the Minister of Health on October 29, 1975.

"Chief of the Anaesthesia Service" means the physician who is responsible to the Medical Advisory Committee and the Board of Governors for the anaesthetic service of the hospital.

"Committee" means the Anaesthesia Drafting Committee.

"district or community hospital" means a general hospital that serves the population of the local area. It provides a smaller range of service than a regional hospital.

"regional hospital" means a general hospital which serves as a district or community hospital for the local population. It provides a wider range of services than a district or community hospital and therefore serves as a referral hospital for persons outside its local area.

"resident" means one of the following categories of physician in training:

(a) Residents in Anaesthesia, who are enrolled in a program of study leading to certification by the Royal College of Physicians and Surgeons of Canada.

(b) Residents in Family Practice or in Continuing Medical Education or in another recognized program, where the period, or periods, of anaesthetic service in total amount to at least six months, and each period consists of at least three months progression of experiences and responsibilities of anaesthetic service.

"university teaching hospital" means a general hospital which serves as a base, district and community hospital for the local population. It provides a wider range of services than regional hospitals and serves as an ultimate referral centre in the province. It is affiliated with the College of Medicine of the University of Saskatchewan and performs a major role in research and education.

V. ANAESTHETIC GUIDELINES AND PRINCIPLES

As a preliminary to the drafting of model Anaesthetic Guidelines and Principles, the Committee studied:

1. Saskatchewan. Board of Inquiry on the Practice of Anaesthesia in Saskatchewan.

   Report. Regina. December, 1976.

2. Canadian Anaesthetists' Society Incorporated. Guidelines for the Minimal Standards of Practice of Anaesthesia.

   Toronto, 1977.

3. Nova Scotia. Department of Health. Guidelines for Anaesthetic Services in the Province of Nova Scotia.

   Halifax. August, 1977.

4. College of Physicians and Surgeons of British Columbia. Guidelines for the Practice of Anaesthesia in the Province of British Columbia.

   Victoria. April, 1976.

5. Professional Corporation of Physicians of Quebec.

   Guide to the Practice of Anaesthesia

   Montreal. March, 1975.

These documents were of much assistance to the Committee in preparing guidelines and principles for the Province of Saskatchewan.

The Committee has prepared guidelines which it believes should be applicable wherever anaesthetic services are provided. It realizes that circumstances may require a flexible interpretation of these guidelines, at least in the immediate future. However, it is the Committee's hope that all hospitals or other facilities providing an anaesthetic service will adopt the Guidelines for the Minimal Standards of Practice of Anaesthesia in Saskatchewan as goals which they will strive to achieve.

The Guidelines form a basis of reasonable and acceptable standards of anaesthetic practice and patient care. These standards are discussed under the headings of:

1. Organization of Hospital Services
2. Responsibilities and Duties
3. Qualifications of Medical Staff
4. Other Personnel
5. Anaesthetic Equipment
6. Pre-Anaesthetic Period
7. Anaesthetic Period
8. Post-Anaesthetic Period

and are designed to encourage the safe practice of anaesthesia.

The detailed guidelines as recommended by the Drafting Committee are attached to this report as Appendix "A".

VI. MODEL RULES AND REGULATIONS FOR DEPARTMENTS OF ANAESTHESIA

It is recognized that hospital departmental policies must be more specific than the anaesthetic guidelines and principles recommended. It is not possible to write a set of policies which could be applicable in all circumstances and in some cases, therefore, different rules and regulations are suggested for base, regional and community or district hospitals.

The model Rules and Regulations for the Service of Anaesthesia should, therefore, be seen as a transformation of the guidelines and principles into practical policies which may be used to regulate the provision of anaesthetic services. The Committee has discussed these policies under the following headings:

1. Qualifications of Members
2. Continuing Education
3. Duties of the Chairman of Service
4. Procedures to be Attended by an Anaesthetist
5. Anaesthetizing Locations
6. Assignment of Cases
7. Consultations
8. Safety
9. On-Call System
10. Pre-Anaesthetic Period
11. The Anaesthetic Period
12. The Immediate Post-Anaesthetic Period
13. Surgical Convalescent Period
14. Interdepartmental Relations
15. Evaluation

Throughout the Service of Anaesthesia - Model Rules and Regulations, the Committee has attempted to identify areas where hospitals with a less formalized medical staff organization may choose to adopt alternative

policies which better reflect their role and resources.

The Committee asks that each hospital examine the Service of Anaesthesia - Rules and Regulations and incorporate the intent of the provisions into its present policies. Some hospitals use a standard format for rules and regulations pertaining to all departments. The Committee does not suggest that the format it has employed is superior to any other, but rather that it covers the important points for the provision of an anaesthetic service.

The specific model Service of Anaesthesia - Rules and Regulations attached as Appendix "C" to this report represent suggested policies by which hospital anaesthetic services might be regulated.

VII. MODEL ANAESTHETIC RECORDS, FORMS AND RECORD KEEPING SYSTEMS

The Drafting Committee examined many anaesthetic forms and developed certain minimal information requirements in its preparation of the three model forms which cover the period during which anaesthesia is administered. It is hoped that these model forms will be adopted by hospitals and other facilities providing anaesthetic services or used as guidelines to modify forms presently in use.

The following model forms are included:

1. Pre-Anaesthetic Assessment - Appendix D
2. Anaesthetic Record - Appendix E
3. Recovery Room Record and Post-Anaesthetic Assessment - Appendix F

VIII. HOSPITAL STANDARDS ACT AND REGULATIONS

The Board of Inquiry did not recommend that the anaesthetic guidelines and principles, when developed, be embodied either in The Hospital Standards Act or the Regulations made under its authority. The Board outlined several reasons for its opinion, and the Committee is in agreement with the Board's reasoning.

The Board stated that Section 53 of Regulation 285/74 under The Hospital Standards Act "Should not be substantially enlarged or made more detailed, but its current provisions as to minimal required anaesthetic and resuscitation equipment should be updated, and the section should require hospitals to prepare and periodically submit to the Minister (for information only) a set of regulations and policy guidelines governing the organization and delivery of anaesthetic services." The Board also recommended that hospital bylaws and regulations require the reporting of deviations from the guidelines to the Minister of Health.

The Drafting Committee has examined Section 53 and those other sections of the Regulations relating to anaesthesia. The proposed changes to the Regulations, as set out in Appendix G, are an attempt to elaborate on, to clarify and to specify those characteristics which will enhance patient safety during the administration of an anaesthetic.

With regard to an amendment to require the submission of each hospital's policies and guidelines relating to anaesthesia to the Minister, and with regard to an amendment to hospital bylaws requiring the reporting of deviations from the policy to the Minister, the Committee disagrees with the Board's recommendations.

The Committee believes that the setting of hospital policy is the role of the hospital board, and that a regulation requiring the submission of these policies to the Government, for information, infringes very much on this role.

Further, unless the policy were made part of the regulation, the Minister may only recommend the adoption by hospitals of certain guidelines and policies, and would have no authority to act upon any deviation from the policy that might be reported to him.

Finally, the Committee sees no justification for singling out anaesthetic services to become involved in such regulation. The Committee believes that medical policy relating to anaesthesia should be set by the hospital board, in consultation with its medical staff, giving consideration to the recommendations of the government and professional organizations, in the same manner as it is set for other medical services.

IX. MEDICAL AUDIT

The Board of Inquiry made recommendations concerning the establishment of regional medical audit programs, with the participation, or, if necessary, under the administration of the College of Physicians and Surgeons, and with funding provided by the Department of Health.

The Board of Inquiry also recommended the extension of the Professional Activity Study's Quality Assurance Monitoring system (PAS-QAM) to the smaller hospitals and the adaptation of the system to better suit the needs of the anaesthetic service and the volume and nature of the clinical work of the smaller hospitals.

The Committee recognizes the growing necessity of some form of quality assurance program in all hospitals, in terms of patient care and compliance with accreditation standards.

Extension and Modification of PAS System

The present policy of the Saskatchewan Hospital Services Plan is to fund those hospitals over 75 beds who request to participate in PAS or PAS-QAM. The Committee is aware that some small hospitals have chosen to participate in PAS without SHSP funding to facilitate the hospital's accreditation process.

Staff need to be trained in abstracting. This is now done at a two day training session sponsored by the Commission on Professional and Hospital Activities, which appears to be sufficient to enable a clerk without formal preparation in health records to complete the abstracts. Training can also be achieved through the assistance of health record consultants over a longer period.

The health records clerk or health records technician must be familiar with the various methods designed to assist the medical staff in conducting a medical care evaluation program (medical audit). The health record consultant from SHSP and from the regional services units in Prince Albert and in Yorkton are presently conducting half-day workshops for health records staff in small hospitals, designed to introduce such items as committee structure, choice of topic, criteria and standard setting, worksheet design, collecting data, and displaying outcomes.

While PAS is not essential, it can be a valuable tool for medical audit and administrative reporting.

The Board of Inquiry recommended the modification of the PAS-QAM system to suit the needs of the anaesthetic service. At present, the only references to anaesthesia appear on the QAM section, where the form used in the data collection indicates general anaesthesia and pre-anaesthetic evaluation.

The PAS system is widely used in North America and any change would require that a specific recommendation be made and concurred to by the Commission on Professional and Hospital Activities and the participating jurisdiction.

As an alternative, hospitals may use the "optional areas", on the PAS or QAM data collection form for special studies which could include anaesthesia. In this regard, Hospital Medical Record Institute (HMRI) in Ontario, an organization with programs similar to PAS, has developed a special coding system specifically relating to the anaesthetic service for use by its participating hospitals. A similar code could be developed for use by Saskatchewan hospitals participating in PAS.

With respect to extension and modification of the PAS system in Saskatchewan, this Commission recommends:

1. that the Department of Health fund all hospitals which are accredited or are actively seeking accreditation, regardless of size, to participate in PAS. These funds should be sufficient to apply to both inpatient and outpatient services.

2. that hospitals using PAS or PAS-QAM be encouraged to use the "optional areas" on the PAS abstract for studies of the anaesthetic service and other clinical administrative studies.

3. that health record consultants conduct workshops designed to teach medical records staff in small hospitals to assist the medical staff in conducting medical audits.

Regional Medical Audit

A more complex part of the Board of Inquiry's recommendation refers to the development of a regional medical audit system.

The Committee believes that a formal peer review mechanism cannot successfully be imposed on physicians as it requires their enthusiastic participation to develop and maintain. A deep commitment is therefore required for the system to operate outside the organization structure of the individual hospital.

The Committee also believes that the design and implementation of a regional medical audit system would be difficult and perhaps unique, and should best be undertaken as a pilot project. For such a project to be successful, the co-operation of the College of Physicians and Surgeons is vital. Their participation in the planning and possible administration of the program would be required.

The number of physicians and small hospitals, as well as the physical distances involved, in each of the regions, would probably make the implementation of a regional medical audit program impossible at present. It is conceivable that a smaller or more limited grouping of individual physicians with a reasonable proximity to each other and a general working relationship might wish to develop a medical audit system.

Appendix H of this report is a conceptual description of a Limited Medical Audit Program. With respect to regional medical audit, the Committee recommends:

1. that the College of Physicians and Surgeons be invited to develop a regional medical audit program as a pilot project.

2. that all or the major part of the funds for such a pilot project be provided by the Department of Health.

3. that the project be evaluated after three years.

The Committee further recommends:

1. that the College of Physicians and Surgeons periodically review and comment upon the medical audit programs of all hospitals.

2. that medical audit programs adress themselves to the quality of all clinical disciplines, including anaesthesia.

X. ANAESTHETIC TECHNICAL ASSISTANTS

The Board of Inquiry recommended the training and employment of a new category of workers, to be known as the "Anaesthetic Technical Assistant" whose members would perform certain duties in the operating room, which might include the monitoring of anaesthetized patients without the personal attendance of the specialist anaesthetist.

The Drafting Committee studied the Board's recommendation in detail and at length, and is unanimous in the opinion that this recommendation should not be implemented.

The practice of anaesthesia is a medical act and the prime responsibility of the physician administering the anaesthesia is to the patient under his care. The monitoring of an anaesthetized patient is a very important part of that care. Any compromise of this standard is regarded as unacceptable.

It seems unfair to those candidates whom one would hope would be attracted to this new career to train them (at significant expense to the province and at some personal sacrifice to the candidates) in order to qualify them for a limited number of positions, all the while hoping the position would become redundant as increased anaesthetist manpower becomes available.

In short, the Committee is of the opinion that the Board's recommendation is at best a short term solution. The Committee's objection to the Board's recommendation is based upon its opinion that certain of the services which would be rendered by the technician are considered to be medical acts. The Committee did recognize that there is a

legitimate need for technical support for the anaesthetist. This support might include servicing, standardization, cleaning, setting up and general maintenance of anaesthetic equipment and need not necessarily come from one distinct category of employee. Rather, it should be regarded as a general claim against the resources of the hospital, for which additional budgetary provision should be made by the Department of Health.

XI. PHYSICIAN MANPOWER

The Committee accepts the Board of Inquiry's findings that the Province of Saskatchewan is experiencing and will continue to experience shortages of specialist anaesthetists unless action is taken.

Our goal must be the provision of appropriately qualified physicians to deliver anaesthesia in this province. This means the acquisition of an increased number of specialist anaesthetists. This goal may be difficult to reach, but the Committee recommends the following approaches:

a) The training in Saskatchewan of additional qualified anaesthetists, through the creation of conditions outlined below which will encourage more medical school graduates to enter the specialty of anaesthesia, and which will encourage present and future specialists to remain in this province:

   i) more attractive remuneration and conditions of practice for anaesthetists;

   ii) increased number of residency positions in anaesthesia without a reduction in other residency programs;

   iii) greater, more positive and earlier exposure of medical students and medical interns to the field of anaesthesia;

   iv) provision of resources and opportunities to allow anaesthetists to spend more time in direct patient care;

   v) greater support for research within the College of Medicine, Department of Anaesthesia, to include salaries, research assistants, facilities and equipment;

   vi) special annual grants to purchase capital equipment for the clinical provision of anaesthesia.

b) Continued active recruitment and provision of funds by the Department of Health for this recruitment of qualified anaesthetists from outside the province.

XII. CONSENT TO ANAESTHESIA

Chapter XI of the Board of Inquiry's Report refers to "Patients' Consents to Anaesthesia." The Board of Inquiry limited its comments on this topic, in anticipation of further recommendations from the Committee on Rights in Relation to Health Care in Saskatchewan. However, that report made no specific recommendations on this point, and the question of consents was not made one of the Terms of Reference of this Committee. Nevertheless, the Board of Inquiry did recommend the development of a new standard consent form as one of the tasks of this Committee.

The inter-relationship of the operative procedure and anaesthesia makes separate forms for consent to the two components of the intervention unnecessary. Nevertheless the Committee recognizes the desirability of drafting the "Consent to Operation and Anaesthesia" in such a manner as to direct the patient's mind more definitely to the question of anaesthesia and its risks and benefits. Secondly, this form should make provision for a statement regarding restrictions, if any, on the type of anaesthetic to be used.

The model consent forms recommended by this Committee are attached as Appendix "I" (Teaching Hospitals) and Appendix "J" (Non-Teaching Hospitals).

XIII. ANAESTHESIA SERVICES IN NON-HOSPITAL FACILITIES

The Board of Inquiry expressed deep concern regarding the provision of anaesthetics outside the controlled environment of the hospital. The Committee wishes to re-emphasize this concerns. The Guidelines and Principles and those other supportive documents presented in this Report apply to all locations - hospital and non-hospital facilities, where general anaesthetics are being administered. Each facility should be equipped with minimum resuscitative equipment. All general anaesthetics should be administered only by a physician with at least minimum hospital privileges in anaesthesia; or if by a dentist, then only by one who has taken a hospital residency program equivalent to that required of physicians before they receive basic hospital privileges in anaesthesia. In no case should the dentist performing the dental procedure also be administering the anaesthetic.

While the Committee has addressed the majority of its comments and directives to hospitals providing an anaesthetic service, non-hospital facilities in which anaesthetics are administered should be guided by the Guidelines, Principles and Standards of Practice presented in the Report.

APPENDIX A

GUIDELINES FOR THE MINIMAL STANDARDS OF PRACTICE OF ANAESTHESIA IN THE PROVINCE OF SASKATCHEWAN

Preamble

The safe practice of anaesthesia is vital to the care of surgical and obstetrical patients, and in recent years has assumed increasing importance in the control of pain, the resuscitation of patients with acute respiratory or cardiac failure, and in the care of patients in intensive care and acute care units.

Both nationally and provincially there is a severe shortage of specialist anaesthetists. While this indicates a need to train and recruit additional fully qualified specialists, we must recognize that, in the foreseeable future, our province will rely on the general practitioner anaesthetist in many circumstances. We must accept as a second goal the broadening of the medical knowledge and technical skills of the physicians presently providing anaesthetic services in Saskatchewan.

These Guidelines form a basis of reasonable and acceptable standards of anaesthetic practice and patient care. In their interpretation, it should be remembered that although the Guidelines represent minimum standards, they may be applied with flexibility when conditions warrant it.

These Guidelines are intended for the use of physicians, individually and as a profession, along with the Boards and staffs of all hospitals providing an anaesthetic service.

The guidelines are presented under the following headings:

1) Organization of Hospital Services
2) Responsibilities and Duties
3) Qualifications of Medical Staff
4) Other Personnel
5) Anaesthetic Equipment
6) Pre-Anaesthetic Period
7) Anaesthetic Period
8) Post Anaesthetic Period

In these guidelines:

(a) "anaesthetist" means a member of the medical staff of a hospital who administers a general or regional anaesthetic to a patient.

(b) "Director of the Anaesthesia Service" means the physician who is responsible to the Medical Advisory Committee and the Board of Governors for the anaesthetic services of the hospital.

(c) "university teaching hospital" - means a general hospital which serves as a base, district and community hospital for the local population. It provides a wider range of services than regional hospitals and serves as an ultimate referral centre in the province. It is affiliated with the College of Medicine of the University of Saskatchewan and performs a major role in research and education.

(d) "base hospital" means a general hospital which serves as a district or community hospital for the local population. It provides a wider range of services than a regional hospital and therefore serves as an ultimate referral centre in the province. It also performs a major role in research and education.

(e) "regional hospital" means a general hospital which serves as a district or community hospital for the local population. It provides a wider range of services than a district or community hospital and therefore serves as a referral hospital for persons outside its local area.

(f) "district or community hospital" means a general hospital that serves the population of the local area. It provides a smaller range of service than a regional hospital.

(g) "resident" means one of the following categories of physician in training:

(a) Residents in Anaesthesia, who are enrolled in a program of study leading to certification by the Royal College of Physicians and Surgeons of Canada.

(b) Residents in Family Practice or in Continuing Medical Education or in another formally recognized education program, where the period, or periods, of anaesthetic service in total amount to at least six months, and each period consists of at least three months progression of experiences and responsibilities of anaesthetic service.

ORGANIZATION OF HOSPITAL SERVICES

Any hospital which provides surgical and obstetrical services should have on its staff physicians appropriately qualified in anaesthesia.

The anaesthetic service shall be properly organized and directed, either as a separate or integrated department of the medical staff. If the medical staff of the hospital is not departmentalized, then one physician on the medical staff should be responsible to the Medical Advisory Committee and the Board of Governors for the anaesthetic service.

RESPONSIBILITIES & DUTIES

The anaesthetic service shall have responsibility for those usual anaesthetics provided to patients for surgical, obstetrical, diagnostic and treatment purposes and shall be directed by a physician member of the medical staff having appropriate training and experience in anaesthesia. He shall have the administrative and supervisory responsibility for the service provided and for the quality of patient care. His responsibilities should include (a) advising the hospital in respect of equipment and agents for the proper administration of anaesthetics and other related activities, (b) the development of regulations or policies concerning anaesthetic safety and (c) the maintenance of necessary records for the documentation and evaluation of all anaesthetic care. Staffing for the delivery of anaesthesia care shall be related to the scope and nature of the anticipated need and the services offered.

An emergency-call list should be established to ensure the availability of an anaesthetist for the hospital.

QUALIFICATIONS OF MEDICAL STAFF

All physicians applying for hospital privileges in anaesthesia for the first time should have completed at least six months of post-graduate training in a Service of Anaesthesia which has a residency program approved by the Royal College of Physicians and Surgeons of Canada. This period may be longer, depending on the grade of privileges being sought.

Those physicians presently having anaesthesia privileges should have proven competence and experience in the Province of Saskatchewan.

There is in Canada generally, and Saskatchewan in particular, a shortage of specialist anaesthetists. Nevertheless, it is considered desirable:

1) that the service of anaesthesia in the university and base hospitals be staffed entirely by specialists, that is medical practitioners certified by the Royal College of Physicians and Surgeons of Canada in the specialty of anaesthesia, or eligible for certification according to the criteria set out from time to time by the Royal College.

2) that the regional hospitals endeavour to acquire and maintain a specialist staff.

3) that district or community hospitals obtain and be directed by the recommendations of the Hospital Credentials Committee of the Saskatchewan College of Physicians and Surgeons in delineating privileges in anaesthesia to medical staff.

Physicians with anaesthesia privileges should be able to perform the essential services necessary in the practice of anaesthesia. This includes the ability to: (1) render the patient insensible to pain for the performance of surgical operations and obstetrical procedures, (2) provide life support during the period of anaesthesia and, (3) provide pre-anaesthetic and post-anaesthetic management of the patient.

An ongoing interest and participation in continuing medical education is essential for every physician practicing anaesthesia, in order that medical knowledge and skill in new techniques be acquired and maintained. This should be done by the physician through independent study, participation in rounds, seminars, short courses, or other educational programs, as well as:

1) for physicians in district or community hospitals, two weeks of observation and supervised experience in a major hospital with specialist staff, every three years.

2) for physicians in regional, base and university hospitals, participation in some organized form of continuing education which should be undertaken more frequently than every three years.

OTHER PERSONNEL

Medical

Co-operation with other physicians responsible for the care of the patient (i.e. surgeons, family physicians) is vital. Procedures should be established for the settlement of disputes without jeopardizing the health of the patient.

Non-Medical

The induction and maintenance of anaesthesia and the supervision of the anaesthetized patient are medical acts and may not be delegated to nursing or technical personnel, except in the case of extreme life-threatening emergency.

However, this should not be interpreted to preclude the carrying out of nursing duties by operating room and recovery room nurses, or the preparation, maintenance and cleaning of anaesthetic equipment by properly trained technical staff.

ANAESTHESIA EQUIPMENT

Wherever anaesthetics are usually administered whether general or regional, there must be immediately available equipment, drugs and supplies appropriate to the anaesthetic techniques being used.

The following list of equipment and supplies is considered to be the minimum that should be available in any anaesthetic area:

Equipment

Stretchers: An appropriate number of mobile stretchers with side rails or restraining devices and with capabilities for raising and lowering the head and foot must be provided for transporting patients, recovery room use. and for the administration of local and regional anaesthetics.

Operating Tables: Standard multi-purpose surgical operating room and case-room tables must be provided. Appropriate accessories (arm rests, drapery screens, masks, breathing bags, head rests, and shoulder rests) should be provided. Intravenous standards in appropriate numbers should be available for each anaesthetic area.

Anaesthetic machines, oxygen supply and anaesthetic gases: In all areas where general anaesthesia is given, anaesthetic machines of standard design must be provided. They must have the capability of providing measured flows of oxygen, plus an appropriate vaporizer for an acceptable volatile agent, if used.

All new anaesthetic machines should conform to the Canadian Standards Association's Standard Z168.3-1978. In particular, in localities where more than one anaesthetic machine is in operation and where any of these have the oxygen flowmeter controls in any position other than downstream on the flowmeter assembly, conversion should be made in accordance with Standard Z168.3-1978, so that complete uniformity in the location of the oxygen flowmeter control valves exist in that locality.

In regional and base hospitals all anaesthetic machines should be provided with scavenging devices capable of maintaining the concentration of trace anaesthetic gases in the anaesthetizing area within limits set by the appropriate authority responsible for standards for occupational health and safety.

Where piped gases are used, all connections between the pipeline and the anaesthetic machine should be gas specific and non-interchangeable. Every machine, whether piped gases or cylinder supplies are used, must be supplied with at least one spare oxygen cylinder. Each cylinder yoke must be pin indexed for the gas for which it is designed.

Where colour coding of gases is used, this should be in accordance with International Standard IS-32.

While many existing pipelines do not conform to the provisions of the standard, all additions to existing systems or new installations should comply with C.S.A. Standard Z305.1-1975 "Non-Flammable Medical Gas Piping Systems."

Oxygen Failure Warning: A low oxygen supply or failure warning system should be installed in the piped systems plus a fail safe or warning mechanism on the anaesthetic machines. For all new gas piping systems and after repairs, tests must be done prior to use, to detect incorrect connections or malfunctions as designated by the Canadian Standards Association.

Ventilators: Anaesthetic ventilators of approved model should be provided in all anaesthetic areas where major surgery is done.

Accessory Cabinet: An anaesthetic drug-and-accessory cabinet, preferably mobile, should be provided for each anaesthetic area. In it should go most of the drugs, solutions, and accessories required for use in administering anaesthetics, plus emergency and resuscitation procedures. Some accessories will also be kept in drawers on the gas machines.

Refrigerator: A refrigerator should be provided in the anaesthetic area to store certain drugs, solutions and blood. Blood must be stored at $4^{\circ}C.$; therefore, not all refrigerators are suitable.

Monitoring: All anaesthetic areas should have immediately available sufficient cardiac monitors for use before, during and after operations on patients with a known or suspected cardiac problem, and in prolonged, major operations. Hospitals where neurosurgery, thoracic surgery, or cardio-vascular surgery is done, should have an appropriate number of multi-channel monitors for recording parameters (e.g. arterial, venous pressures) other than the electrocardiograph.

Defibrillator: A defibrillator should be immediately available to any area where anaesthetics are administered for use in emergency situations such as cardiac arrest, or ventricular fibrillation.

Suction: If piped, central vacuum for suction is not provided, there must be electric portable suctions in appropriate numbers for each anaesthetic area. Even if central suction is provided, portable electric suction should be available for emergency situations.

Crash Cart: A crash cart should be immediately available to every anaesthetic area to deal with cardiopulmonary arrest. It should contain certain emergency drugs, airways, tracheal tubes, laryngoscope, and a means of providing manual ventilation. A call system for emergencies should be provided to signal a cardiopulmonary arrest, and staff should be properly trained in emergency procedures.

All anaesthetic equipment must be inspected regularly and maintained in good order. Inspection must be recorded.

All equipment in contact with the patient must be cleaned and disinfected by accepted procedures before being used on a patient. The efficiency of the disinfection should be confirmed by appropriate bacteriological testing.

All electrical equipment in the operating room should conform to the Canadian Standards Association's current publication, Electro-medical Equipment, and must be checked at regular intervals by a qualified person to ensure that it is in proper working order and these inspections must be recorded.

Drugs & Supplies

A list of the drugs and supplies commonly used in anaesthesia and resuscitation is included below. Some may be kept in the anaesthetizing area in a cabinet; others need to be kept in a refrigerator. All should be kept within easy reach. Back-up supplies should be kept in an anaesthesia stockroom or in the hospital pharmacy.

Rapidly acting intravenous anaesthetics
Muscle relaxants
Vasopressors - Cardiac stimulants
Peripheral vasodilators and anti-hypertensive agents
Alpha and beta blocking agents
Anti-arrhythmic agents and diuretics
Anti-asthmatic and anti-histamine agents
Corticosteroids and belladonna drugs
Sedatives, analgesics and tranquilizers
Respiratory stimulants and narcotic antagonists
Anti-emetic drugs and oxytoxic agents
Drugs for reversal of muscle relaxants
Anti-coagulants and antagonists
Local anaesthetic drugs
Ampoules of sterile water, saline, potassium chloride and calcium chloride
Various intravenous solutions, including mannitol; administration sets for solutions and blood
Various size syringes
Intravenous needles and catheters
Suction catheters, ridged tonsil suction
Oro- and naso- tracheal tubes, connectors, oral airways
Files for ampoules

Regulations relative to anaesthetic safety should be developed by the Chief of the Anaesthesia Service, together with the appropriate hospital personnel, in order to minimize the hazards from fires, explosions and electrical shock. Model Fire Safety Rules and Regulations For Anaesthetizing Locations are included as Appendix B. Standards which may from time to

time be established by the Occupational Health Division of the Department of Labour must be adhered to.

The hospital administration, with the advice of the Chief of the Anaesthesia Service, must establish, according to its capabilities, and enforce such safety regulations as are approved regarding the preparation, storage, identification and use of anaesthetic drugs and agents.

The Canadian Standards Association has prepared standards pertaining to the performance, installation and maintenance of anaesthetic equipment. These standards should be followed when purchasing new equipment and making new installations. For information the current references are:

Safety Standards for Electrical Equipment

C.22.2 No. 121-1959, Electric Heating Equipment for Medical and Dental Use;
C.22.2 No. 114-1961, X-ray Equipment;
C.22.2 No. 125-1973, Electromedical Equipment.

Others

Z.39-1959, Code for Marking of Portable Compressed Gas Containers to Identify the Material Contained;
Z.32-1963, Code for Use of Flammable Anaesthetics (Safe Practice for Hospital Operating Rooms);
Z.32.1-1970, Code for Prevention of Explosions or Electric Shock in Hospital Operating Rooms;
Z.168.1-1970, Tracheal Tubes;
Z.168.2-1967, Endotracheal Tube Connectors and Adaptors;
Z.168.3-1978, Continuous Flow Inhalation Anaesthetic Apparatus;
Z.168.4-1975, Keyed Filling Devices for Liquid Anaesthetics;
Z.168.5-1978, Lung Ventilators;
Z.65-1966, Radiation Hazards from Electronic Equipment;
Z.305.1-1975, Non-Flammable Medical Gas Piping Systems;
Z.76-1973, Performance of Child Resistant Packaging;
Z.180.1-1973, Purity of Compressed Air for Breathing Purposes;
Z.275.1-1974, Hyperbaric Facilities;

Copies of these codes may be obtained by writing to the following address:

Canadian Standards Association, 178 Rexdale Blvd., Rexdale, Ontario, Canada, M9W 1R4

THE PRE-ANAESTHETIC PERIOD

There should be a delineation of pre- and post-anaesthetic responsibilities by the Chief of Anaesthesia. Written policies relative to anaesthesia care should include the following:

1) The pre-anaesthetic evaluation of the patient by a physician, with appropriate documentation in the patient's health record of pertinent information relative to the choice of anaesthesia.

2) The pre-anaesthetic assessment should, if possible, be conducted personally by the anaesthetist scheduled to care for the patient.

3) At the time of the pre-operative visit, the anaesthetist shall identify the patient and the site and side of the operation, take such history and carry out such physical examination as is necessary to permit the establishment of the physical status of the patient, his suitability as an anaesthetic risk, and to choose an appropriate anaesthetic. The history should include inquiries as to previous medications, unusual reactions or responses to drugs and other anaesthetic experiences, including problems and complications.

Any difference of opinion between the operating surgeon and the anaesthetist concerning the care of a patient should be resolved before the time of the planned operation.

Appropriate laboratory investigations indicated by the history and physical examination shall be carried out on all patients, taking into consideration their physical condition and the proposed operation.

Investigations should include:

1) Complete Blood Count.
2) Urinalysis.
3) E.C.G. for patients over 40 years of age.
4) Chest X-ray, taken within the six months preceding the procedure.
5) Such other specific investigations appropriate to the patient and the operation involved.

The surgeon and/or the attending physician should share a responsibility to communicate to the anaesthetist and to report on the health record unusual problems known to them which may affect the choice of anaesthesia.

A policy should be followed concerning the minimum delay from the time of the last oral intake to the induction of anaesthesia for elective surgery. While a complete emptying of the stomach can never be guaranteed in the presence of pain, trauma, apprehension, narcotics, gastrointestinal disorders or medications, a minimum time of five hours is suggested except under emergency conditions. The same rules should apply for regional anaesthesia.

Emergency surgery should be undertaken taking into consideration the risks of delaying surgery versus the risks of aspiration should anaesthesia be induced.

Premedication, if indicated, should be by written order of the anaesthetist. The order should be specific as to dosage, time and route of administration.

THE ANAESTHETIC PERIOD

Before starting an anaesthetic procedure the anaesthetist is responsible for the following:

1) The thorough inspection of the anaesthetic machine and all other anaesthetic equipment.

2) That a primary and reserve source of oxygen are available.

3) The proper identification of all drugs and agents to be administered.
4) A review of the patient's condition before induction.

Careful attention shall be paid to the manufacturer's recommendation pertaining to the use, handling and disposal of disposable, non-reusable items of anaesthetic equipment.

The anaesthetist's primary responsibility is to the patient under his care and he should remain with his patient during the anaesthetic period. Under exceptional circumstances only and in order to provide life saving emergency care to another patient, the anaesthetist may have to delegate temporarily the routine care of his patient to a competent person. The practice of simultaneous administration of anaesthesia for operative procedures to two patients by one anaesthetist is not recommended. However, it may be appropriate in an obstetrical unit to start a second epidural anaesthetic procedure after it has been determined that the first patient has shown no complications or adverse effects and is being adequately observed by a competent person.

Residents, as they are medical practitioners in training, may administer anaesthetics without direct supervision. The extent of supervision required by the resident shall be determined by the supervising anaesthetist, taking into consideration:

1) the experience, skill and judgment of the resident,
2) the condition of the patient,
3) the nature and gravity of the operation, and
4) the anaesthetic techniques and agents to be used.

Other bona fide medical students may only participate in the administration of an anaesthetic under the direct and continuous supervision of the attending anaesthetist in approved teaching institutions.

An adequate record of the patient's vital signs should be made during the course of the anaesthesia. The time, dosage, form, route and the amount of all drugs and fluids administered should be recorded on the patient's health record.

The patient should be positioned, handled and transported in such a manner as to minimize the risk of injury.

All anaesthetists should be proficient in performing tracheal intubation. It is recognized that new techniques must be developed by qualified investigators in approved research programs. As a general rule the practicing anaesthetist should not introduce any new techniques into his clinical practice until he is familiar with the known possible hazards associated with the new technique.

Special care should be taken to ensure that the surgical drapes do not prevent the anaesthetist from properly observing the state of his patient throughout the operation. Careful and continuous monitoring of the cardiovascular and respiratory systems using a blood pressure apparatus and a stethoscope is especially important.

THE POST-ANAESTHETIC PERIOD

The care of the post-anaesthetic patient should not be delegated to the recovery room nurse until the anaesthetist has ascertained that the patient's condition is such that the patient may be safely observed and cared for by that nurse.

The anaesthetist should discuss the care of the patient with the recovery room staff responsible for the care of the patient. This should include respiratory therapy if indicated. Special problems related to the patient's safe emergence from the anaesthetic state should be communicated to the recovery room staff responsible for the patient's care.

The anaesthetist is responsible for leaving orders for the discharge of patients from the recovery room.

Any complications or incidents occurring in the post-operative period bearing any relation to the anaesthetic should be recorded either on the recovery room record or in the progress notes on the patient's health record.

A post-anaesthetic visit by the anaesthetist is desirable.

APPENDIX B

MODEL FIRE SAFETY RULES & REGULATIONS FOR ANAESTHETIZING LOCATIONS

COMMENT: 1) Each facility in which an anaesthetic service is provided should have fire safety rules and regulations consistant with these models and any directives issued by the Office of the Fire Marshall.

2) Readers should note that they must combine the suitable sections as suggested below to create complete regulations, ie:

Section A - Common to all locations

and Section B - Where flammable anaesthetic agents are permitted

or

Section A - Common to all locations

and Section C - Where flammable anaesthetics are not permitted.

3) Regulations for each participating hospital should be dated and signed.

A. Common to all Locations

(1) There shall be no smoking and no open flame in any anaesthetizing area.

(2) No grease or oil shall be used on any anaesthetic gas connection.

(3) All electrical equipment, including equipment owned by a physician, shall be inspected by and acceptable to the Engineering Department of the hospital before it is used in an anaesthetizing area.

(4) All electrical and electronic monitoring equipment and wiring shall be regularly inspected by the Engineering Department and written reports of such inspection maintained.

(5) All electrical or electronic equipment known or suspected to be defective shall immediately be removed from the area and reported to the Engineering Department for inspection and repair.

(6) Portable equipment used in the anaesthetizing area shall be equipped with power cords whose plugs are compatible with the receptacles installed in this area. All portable equipment shall be provided with a positive grounding facility for connection to the protective grounding system with the exception of double insulated equipment.

(7) The electrical wiring system shall be isolated for protection against electrical shock. The integrity of the isolation shall be monitored by a ground hazard indicator. If the indicator indicates a fault, the room shall not be used until the fault has been identified and corrected, and clearance has been received from the Engineering Department.

(8) Connections for all anaesthetic machines, gas cylinders and high pressure anaesthetic gas connecting tubes shall be non-interchangeable and shall conform to CSA standards.

(9) The connecting of compressed gas cylinders to anaesthetic machines shall be the responsibility of the anaesthetist or his delegate.

(10) Wall gas lines in each operating room and recovery room shall be regularly inspected and written reports of such inspections maintained.

COMMENT: In this and similar sections, the hospital may wish to define the personnel and the frequency of inspections.

(11) Anaesthesia machines and ventilators shall be inspected, maintained and cleaned as directed by the Chief of the Service of Anaesthesia.

(12) Masks, tubes and bags for anaesthetic equipment shall be changed, cleaned, and sterilized by accepted methods.

AND

B. Where Flammable Anaesthetics Are Permitted: Add the following:

(13) No flammable anaesthetic agent, germicide or other flammable chemical shall be stored in any anaesthetizing area in this hospital. They shall be safely stored in an area separate from the anaesthetizing area.

(14) Silk, wool or synthetic textile materials, except untreated rayon, should not be used in an anaesthetizing area for non-apparel purposes, or for outer garments, except hosiery. Hosiery and underclothing in which the entire under-garment is in close contact with the skin may be of silk, wool or synthetic material.

(15) Conductive footwear must be worn in this area and conductivity checked by conductometer before entering the operating room.

(16) Operating Room floors and all equipment shall be conductive within recognized limits of conductivity and shall be tested at regular intervals to assure that acceptable conductivity is maintained.

(17) Electrical switches and wall outlets shall be explosion-proof or they must be at least 1.8 metres above floor level. Only equipment approved for use in the presence of flammable gases may be used in the Operating Room.

(18) Copies of all current standards relevant to Operating Room safety shall be available in the hospital.

(19) The hospital shall delegate the responsibility for the enforcement of safety regulations to an individual or a position such as Chairman of the Operating Room Committee.

or

C. Where Flammable Anaesthetics Are NOT Permitted

(13) No flammable anaesthetic agent, germicide, or flammable chemicals shall be used, stored in, or transported through any anaesthetizing area in this hospital.

(14) Copies of all current standards relevant to operating room safety shall be available in the hospital.

(15) The hospital shall delegate the responsibility for the enforcement of safety regulations to an individual or a position, such as Chairman of the Operating Room Committee.

APPENDIX C

SERVICE OF ANAESTHESIA - MODEL RULES & REGULATIONS

COMMENT: Community or district hospitals, with non-departmentalized medical staff, might use as a title "Rules & Regulations for Anaesthetic Services."

1) Qualifications of Members

COMMENT: Each hospital should include one of the following sections outlining the qualifications of a member of the service, or, in the case of a community or district hospital, the qualifications required for holding privileges in anaesthesia.

A. University Teaching Hospital

All members of the service shall:

(a) Have the FRCP(C) or hold specialist qualifications judged to be equivalent, or

(b) Be eligible for certification according to the criteria set out from time to time by the Royal College of Physicians and Surgeons of Canada.

B. Base Hospital

All members of the service shall:

(a) Have the FRCP(C) or hold specialist qualifications judged to be equivalent, or

(b) Be eligible for certification according to the criteria set out from time to time by the Royal College of Physicians and Surgeons of Canada, or

(c) Be licensed physicians with proven competence and currently practising anaesthesia in this hospital.

C. Regional Hospital

All members of the service shall:

(a) Be licensed physicians who have successfully completed at least six months of formal training in anaesthesia, as evidenced by a certificate or written statement from the Director of Training of the institution where the training was received, or

(b) Be licensed physicians with proven competence and currently practising anaesthesia in this hospital.

D. Community or District Hospital

In order to qualify for privileges in anaesthesia, a physician shall:

(a) Be a licensed physician who has successfully completed at least six months of formal training in anaesthesia, as evidenced by a certificate or written statement from the Director of Training of the institution where the training was received, or,

(b) Be a licensed physician with proven competence and currently practising anaesthesia in Saskatchewan.

In all cases of application for privileges in anaesthesia, the hospital will obtain and be guided by the recommendations of the Hospital Credentials Committee of the College of Physicians and Surgeons of Saskatchewan.

2) Continuing Education

In all cases of initial application or application for re-appointment for anaesthetic privileges, where the qualifications on which the application is based were completed more than five years before the date on which initial application or application for re-appointment is being made, the physician making application shall provide satisfactory evidence of participation in continuing education programs in anaesthesia in the previous five years.

COMMENT: Individual hospitals may wish to make the requirements for continuing medical education more or less specific. However, the rules should recognize the need for the physician practising anaesthesia to maintain and update his knowledge and skill.

3) Duties of Chief of the Service of Anaesthesia

COMMENT: The title of this position may differ, especially in non-departmentalized hospitals. The committee has chosen to use the position title "Chief of the Service of Anaesthesia". However, such other terminologies as "Chairman" or "Head" and "Department" could have been substituted. The primary concern is that there should be a physician in each hospital with administrative and supervisory responsibility for the anaesthetic service, and the duties of that position should be defined.

The Chief of the Service of Anaesthesia shall have authority for the administration and professional direction of the anaesthetic service subject to the authority of the Medical Advisory Committee.

The duties of the Chief of the Service (or his designated alternate) are to:

(a) exercise general supervision over the professional care given by all members of the service.

(b) co-operate with other clinical services and the hospital administration in matters affecting patient care.

(c) ensure that an adequate review and analysis of the clinical work of the service is done, in keeping with current practice and standards.

(d) be a member of the Medical Advisory Committee (or in smaller hospitals of the body with a similar role) to advise with regard to all functions of the anaesthetic service.

(e) chair regular meetings of the service, in number as determined by the medical staff bylaws, with the right to call and preside at special meetings as necessary, ensuring that minutes are properly recorded and decisions are reported or implemented.

(f) attend, or arrange for a substitute to attend, any hospital meeting at which the service should be represented.

(g) make recommendations on behalf of the service on procurement of drugs, supplies, instruments and equipment needed for patient care.

(h) initiate educational programs for service members and hospital staff, as necessary.

(i) advise the Credentials Committee of the medical staff in the consideration of application for membership, changes in privileges and status, etc.

(j) allocate or oversee the allocation of all anaesthetic bookings.

(k) prepare an emergency call list for the Service of Anaesthesia.

(l) consider requests for vacation, leaves, and other absences, in order that an adequate anaesthetic coverage is maintained.

(m) receive notice of all serious risks and untoward events associated with anaesthesia and provide appropriate documentation as required by the hospital.

(n) have authority to advise on or intervene in the anaesthetic management of any patient.

4) Procedures to be Attended by an Anaesthetist

The following procedures must be attended by an anaesthetist:

(a) all general anaesthetics.

(b) major regional anaesthetics, such as subarachnoid, peridural, plexus block and total limb anaesthetics.

(c) any cases in which the condition of the patient or the magnitude of the operative procedure indicates that another physician should be present to monitor vital signs, administer additional sedation if required and perform any ancillary duties which should not be delegated to the nursing staff.

5) Anaesthetizing Locations

General and major regional anaesthetics shall be administered only in areas which are appropriately equipped for such procedures and these areas shall be designated by the hospital.

6) Assignment of Cases

All cases shall be assigned to members of the service by the Chief of the Service. He may take into consideration the requests of the surgeon or the patient, but the over-riding consideration must be quality of patient care and the efficient operation of the service and the operating suite.

COMMENT: It may be necessary to revise this rule for smaller hospitals. However, the decision to assign a particular case to a particular anaesthetist should be based primarily on patient care and only secondarily on other considerations. This principle should be recognized when making any change to the above rule.

7) Consultations

(a) In all cases where there is doubt as to the best measures to be utilized, consultation should be sought with another qualified anaesthetist or other physicians as appropriate.

(b) The fact that a consultation has been requested should be indicated on the health record, along with the consultation report.

(c) Requests for an anaesthetic consultation may be directed to an individual anaesthetist or to the Chief of the Service who will assign the consultation to a member of the service.

(d) If an anaesthetic consultation is done at the request of the surgeon, the Chief of the Service shall assign the consulting anaesthetist to that anaesthetic, if circumstances permit.

(e) When, by reason of emergency, an anaesthetist must act beyond his privileges in anaesthetizing a patient whose condition is such that he cannot be transferred to a larger centre, then consultation by telephone should be sought with a specialist anaesthetist.

8) Safety

Members of the service shall comply strictly with hospital rules governing the prevention of fires, explosions, electrical and other hazards.

COMMENT: Safety regulations apply to everyone and therefore have not been included in the Service of Anaesthesia Rules and Regulations. Model Fire Safety Rules and Regulations for Anaesthetizing Locations are appended to this report. (Appendix B)

9) On-Call System

(a) An anaesthetist shall be available 24 hours a day for emergency anaesthetic procedures.

(b) The Chief of the Service shall establish the call schedule and all members of the service, unless excused, shall participate in the call schedule.

(c) The "on-call" anaesthetist must be immediately available by telephone and available at the hospital within a reasonable period of time.

(d) The "on-call" anaesthetist may call in another anaesthetist if the volume of work indicates.

(e) If the surgeon responsible for an emergency case wants an anaesthetist other than the on-call anaesthetist to administer the anaesthetic, he is personally responsible for making alternative arrangements.

10) The Pre-Anaesthetic Period

(a) Each patient scheduled for surgery shall be seen by an anaesthetist prior to the operation.

(b) If possible, the pre-anaesthetic visit should be made by the anaesthetist assigned to the case.

(c) At the time of the pre-anaesthetic visit, the anaesthetist shall make such physical examination as is necessary to establish the status of the patient, his suitability as an anaesthetic risk, to choose an appropriate anaesthetic and to order pre-operative sedation, if necessary.

(d) The history should indicate the following details:

(i) present and previous medication
(ii) adverse reactions to drugs
(iii) previous anaesthetic experience, complications

(e) Appropriate laboratory investigations shall be carried out on all patients, taking into consideration the physical condition and the proposed operation. These should include as a minimum:

(i) haemoglobin concentration and packed cell volume
(ii) urinalysis
(iii) electrocardiogram for patients over the age of 40 years or with a history of cardiovascular problems.
(iv) chest x-ray within six months of the scheduled operation, for patients over the age of 15.

(f) The details of the pre-anaesthetic assessment shall be recorded on the pre-anaesthetic assessment form and shall become part of the patient's health record.

(g) The proposed anaesthetic technique should be explained to the patient so that he/she will have a reasonable understanding.

(h) In the absence of over-riding medical considerations, any preferences and objections of the patient shall be observed.

(i) The anaesthetist shall write orders for pre-operative medication, specific as to drug, time, dosage and route, as well as time of last oral intake.

(j) For elective procedures, the time of last oral intake shall be not less than five hours prior to the scheduled operation.

11) The Anaesthetic Period

(a) The attending anaesthetist is responsible for the patient assigned to his care from the time that the patient enters the surgical suite until the patient is discharged from the Recovery Room.

(b) Before starting the anaesthesia, the anaesthetist shall check the following:

(i) the patient's identify, as confirmed by examination of the patient's wrist band.
(ii) the site and side of the proposed operation.
(iii) that the patient's consent is on the health record.
(iv) the patient's immediate pre-operative condition.
(v) that all necessary equipment is available and in working order.
(vi) that primary and reserve oxygen are available.
(vii) that all anaesthetic agents and ancillary drugs are at hand.

(c) Anaesthesia shall not be induced until the surgeon is present in the surgical suite and available to start the operation.

(d) The administration of anaesthesia is a medical act and must be conducted by a member of the service.

Where applicable,

(i) A resident enrolled in the Royal College program in anaesthesia or a physician enrolled in a formal training program in anaesthesia may administer an anaesthetic under the direct or indirect supervision of a member of the service. (The extent and personnel of such supervision is to be determined by the Chief of the Service.

(ii) A bona fide student of other medical training programs may participate in the administration of an anaesthetic only under the direct and continuous supervision of a member of the service.

(e) The anaesthetist must not leave the operating room during the administration of an anaesthetic, except to assist in the management of an immediate life-threatening emergency elsewhere, when he shall delegate some responsible person to replace him temporarily.

(f) Unconscious patients shall be carefully observed and shall be positioned in such a way that no physical injury shall result, and adequate pulmonary ventilation shall be ensured. Special care shall be exercised when using heating or cooling appliances. Potential sites of pressure are to be protected and interference with circulation watched for. The use of arm boards shall be minimized during operations and whenever possible the patient's arms shall be kept by his sides.

(g) The anaesthetist shall complete an anaesthetic record containing the following information:

(i) pre-anaesthetic condition of the patient.
(ii) physical techniques and equipment used.
(iii) name, dosage, route and time of administration of anaesthetic agents and drugs.
(iv) intravenous therapy, including blood transfusion.
(v) vital signs, checked at intervals of not more than 10 minutes.
(vi) any diagnostic and therapeutic procedures carried out.
(vii) the immediate post-operative condition of the patient.

This record shall be completed and signed by the anaesthetist.

(h) Blood to be transfused by the anaesthetist shall be checked by him/her in the presence of a witness.

(i) Narcotics administered by the anaesthetist shall be recorded on the narcotics register, signed for, and discarded quantities accounted for.

12) <u>The Immediate Post-Anaesthetic Period</u>

(a) All post-operative patients shall be admitted to a recovery facility. The only exceptions may be patients admitted immediately to ICU or patients who have undergone minor procedures under local anaesthesia.

(b) With the permission of the Chief of the Service patients may be admitted to the Recovery Room for regional anaesthesia for pain, assessment of unconsciousness, or other special circumstances.

(c) The anaesthetist shall accompany his patient to the Recovery Room and observe the patient until his condition is such that the patient may be safely observed and cared for by the Recovery Room staff.

(d) The anaesthetist shall ensure that orders have been written for post-operative pain medication, respiratory therapy and other orders related to the anaesthetic or the consequences thereof.

(e) The anaesthetist shall discuss the present condition, special problems and continuing care of the patient with the Recovery Room nurse assigned to that patient.

(f) The anaesthetist shall leave orders for the discharge of patients from the Recovery Room. The service may choose to establish criteria for discharge from the unit. Patients meeting these criteria may be discharged by the Recovery Room nurse. In all other cases, discharge shall be by the written order of the anaesthetist. Such criteria should be signed by the Chief of Service, dated and posted.

13) Surgical Convalescent Period

(a) Post-operative visits are encouraged, and should be a requirement in special circumstances such as unusual operative or anaesthetic procedures or prolonged anaesthesia.

(b) The anaesthetist shall complete the post-anaesthetic record, indicating the patient's post-anaesthetic condition.

14) Inter-Departmental Relationships

(a) Close liaison should be maintained with the surgeon or attending physician on all matters pertaining to the welfare of the patient throughout the pre-anaesthetic, anaesthetic and post-anaesthetic periods.

(b) The anaesthetist shall have complete charge of the choice and means of administration of the anaesthetic to be given, having due regard to the wishes of the surgeon and the patient, and he shall be completely responsible for the conduct of the anaesthetic.

15) Evaluation

(a) All major complications and untoward events occurring during or after anaesthesia and bearing any relation to the anaesthetic should be recorded in the Anaesthetic Record or the Progress Notes. This information should also be reported to the Chief of the Service in order that it can be discussed at the service meeting.

(b) The service shall participate actively in the hospital's medical audit program.

(c) The attending anaesthetist shall complete a report for the Committee for the Study of Anaesthetic and Operative Deaths of the College of Physicians and Surgeons, in all cases where such a report is required by the Regulations under The Hospital Standards Act.

APPENDIX D

PRE ANAESTHETIC ASSESSMENT

NAME:		SEX:	
ROOM #:	RECORD #:	AGE:	
PRE-OP DIAGNOSIS:			
DATE:	TIME:	CONSENT:	ANAESTHETIST:

HISTORY

PREVIOUS ANAESTHETICS:		
CARDIOVASCULAR PROBLEMS:		
GENERAL CONDITION:	HT.	WT.
ALLERGIES:	BLEEDING TENDENCIES:	
DRUGS:		

PHYSICAL EXAM

CARDIOVASCULAR:	B.P.:
	PULSE:
RESPIRATORY:	MOUTH:
	NOSE:
	THROAT:
NERVOUS SYSTEM:	
G.U.	
G.I.	
OTHER:	

INVESTIGATIONS:	Hgb:	E.C.G.:
	Urine:	
OTHER:		X-RAY:

A.S.A. STATUS:

SUMMARY:

Signature of Anaesthetist

RECORD OF ANAESTHESIA

APPENDIX E

SURGEON				DATE			
PRE-OP DIAGNOSIS							
PRE-OP CONDITION							
ALLERGIES				E.C.G.			
HEIGHT	WEIGHT	TEMPERATURE	B.P.	TIME RECORDED	RISK ASA 1 2 3 4 5		OTHER
URINE	HB / HCT	ELECTROLYTES	NA / K	CL / HCO3	BLOOD GROUP		LAB
PREMEDICATION (1)			TIME	PREMEDICATION (2)			TIME
STEROIDS	SEDATIVE		ANTIBIOTICS	CARDIOVASCULAR			OTHER
OPERATION							PUPILS:
							NOSE:
							MOUTH/TEETH:
TIME ANAES BEGAN		TIME OPERATION BEGAN		TIME ANAES ENDED		THEATRE	THROAT:

TEMP	CVP	BP	15	30	45	2HR	15	30	45	2HR	15
41	30	200									
39	25	190.									
37	20	180									
35	15	170									
33	10	160									
31	5	150									
29	0	140									
27	-5	130									
		120									
		110									
		100									
		90									
		80									
		70									
		60									
		50									
		40									
		30									
		20									
		10									

CODES:
TEMP + PULSE
CVP
B.P.X RESP

INDUCTION:

MAINTENANCE:

RELAXANTS:

MONITORING EQUIPMENT

REMARKS

REMARKS

ANAES AGENTS AND IV FLUIDS

CIRCUIT

TECHNIQUE | AIRWAY: ORAL / NASAL | ET TUBE: SIZE / CUFF | NT TUBE: SIZE / R/L / CUFF

BLOCK-REGION		APPROACH	SPINAL/EPIDURAL		LEVEL		VENTILATOR
DRUG	CONC	DOSAGE	DRUG	CONC	DOSAGE	TYPE:	T. VOLUME
PRESSOR		CONC	PRESSOR		CONC	RATE:	PRESSURE
DRUGS			LOSSES			BLOOD FLUID	

POST OP CONDITION | MOVED TO | TIME

ANAESTHETIST

FORM 116-5M CHART

RECOVERY ROOM RECORD

APPENDIX F

DATE:	TIME ADMITTED:	ANAESTHETIST:
SURGEON:		ACCOMPANIED BY:
OPERATION:		
ALLERGIES:		NURSE:

CONDITION ON ARRIVAL

- ☐ NON-REACTING
- ☐ REACTING
- ☐ CONSCIOUS

COLOUR

RESPIRATION

PULSE

VENTILATOR

MONITOR

CODE:
B.P. X
PULSE ●
RESP ○
TEMP. +
C.V.P. *

TIME

240 220 200 180 160 140 120 100 80 60 40 20

AIRWAY			O2-THERAPY			FLUID ADMINISTRATION						DRAINS
	IN AT	OUT AT	ROUTE	L/MIN	TIME		O/W	BLOOD	SALINE	ORAL		
ORAL			MASK			O.R.						
NASAL			NASAL			R.R.						
E.T.						TOTAL						

OUTPUT			MEDICATION				
SITE	AMT	TIME	TIME	DRUG	DOSE	ROUTE	SIGN
TOTAL							

NURSES NOTES

TIME OF DISCHARGE

REG. NURSE

POST-OP VISIT DATE: TIME

COMPLICATIONS- PULMONARY C.V.:

G.I. G.U. NEURO:

THROAT MOUTH TEETH

OTHER

ANAESTHETIST

APPENDIX G

PROPOSED REVISIONS TO REGULATIONS UNDER THE HOSPITAL STANDARDS ACT

(Regulation 285/74)

INTERPRETATION

S. 1 (12) "general anaesthetic" means the administration of any substance or substance by whatever route with the intention of producing insensibility to pain through the reversible abolition of consciousness.

(14) "major regional anaesthetic" means subarachnoid, peridural, plexus block and total limb anaesthetics.

(20) (i) "JURSI" or "Junior Undergraduate Rotating Student Intern" means a person who is receiving instruction in the final year of study in the College of Medicine at the University of Saskatchewan and whose name appears on the Educational Register maintained by the College of Physicians and Surgeons of the Province of Saskatchewan pursuant to Section 28 of the Medical Profession Act.

(ii) "medical intern" means an intern or resident whose name appears on the Educational Register maintained by the College of Physicians and Surgeons of the Province of Saskatchewan, pursuant to Section 28 of the Medical Profession Act.

SURGICAL OPERATIONS

Sec. 51 (2) Omit - Repositioned to 53(1)

Sec. 51 (3) Before a patient is submitted to surgery involving the administration of a general or major regional anaesthetic, a complete history, physical examination and a recorded pre-operative diagnosis shall be furnished by the surgeon or any medical practitioner authorized by him except that where the surgeon is of the opinion that the delay occasioned in obtaining such history and making such examination would be detrimental to the patient, he shall so state in writing, but in such event, the pre-operative diagnosis shall be furnished and signed by the surgeon.

ANAESTHESIA

Sec. 53 (1) General or major regional anaesthetics shall be administered only by a physician or by a member of the medical intern staff of the hospital under the supervision of a physician. The physician administering the anaesthetic or supervising the administration of the anaesthetic shall be a physician other than the surgeon or, in the case of a major operation, the physician assisting the surgeon.

Sec. 53 (2) Rules governing the administration of anaesthetics to poor-risk patients shall be prescribed in the Rules and Regulations under the medical staff bylaws of the hospital.

Sec. 53 (3) A pre-anaesthetic assessment shall be made of every patient prior to the administration of a general or major regional anaesthetic. The pre-anaesthetic assessment record shall include such details of medical history, physical examination and laboratory investigation as will enable the anaesthetist to evaluate the physical status of the patient and to choose a suitable anaesthetic.

Sec. 54 (4) Following surgery, the anaesthetist shall prepare a written record showing:

(i) pre-operative physical state of the patient.
(ii) type of anaesthetic given.
(iii) amount and duration of anaesthesia.
(iv) vital signs taken at frequent intervals.
(v) monitoring equipment used.
(vi) additional drugs or special procedures.
(vii) condition of the patient at the conclusion of the operation.

Sec. 54 (5) The immediate post-anaesthetic care of the patient shall be the responsibility of the anaesthetist.

Sec. 54 (6) A record shall be kept of the patient's condition during the immediate post-operative period, including vital signs and any abnormality observed by the nursing staff.

Sec. 55 (1) In each location of a hospital where anaesthesia of any kind is administered, the following minimum equipment shall be provided:

(a) A source of oxygen to which is attached a flowmeter with a bag and mask, and a reserve source of oxygen.

(b) A source of suction sufficiently powerful to remove secretions and vomited matter from the patient's mouth and airway.

(c) The necessary equipment for the management of the airway including tracheal tubes, airways of different sizes and laryngoscopes.

Sec. 55 (2) Wherever a general or major regional anaesthetic is administered, the following additional equipment shall also be immediately available:

(a) anaesthetic machine.
(b) defibrillator.
(c) emergency drugs and supplies.
(d) electrocardiographic monitor.

Sec. 55 (3) Where an anaesthetic is administered for the purpose of electroconvulsive therapy, the following additional equipment shall also be immediately available:

(a) defibrillator.
(b) emergency drugs and supplies.
(c) electrocardiographic monitor.

Sec. 55 (4) Precautions shall be taken to ensure that all equipment is maintained in a serviceable condition for immediate use.

APPENDIX H

EXAMPLE OF A LIMITED MEDICAL AUDIT PROGRAM

A number of doctors in a certain geographic area with established working relationships would be seen to develop an interest in formal peer review processes. Each would have active medical staff membership and privileges at his own hospital but believes it is too small to support a viable medical audit program. These general practitioners would constitute themselves as a Medical Audit Committee which would serve as the Medical Audit Committee for each hospital. (The Medical Audit Committee may wish to invite certain specialist physicians to join them on a consulting basis to provide additional expertise to their review).

The services of a Health Record Analyst (H.R.A.) would be obtained on a part time basis perhaps from the Regional Services Unit for that region.

The Medical Audit Committee, including the H.R.A., would meet on a regular basis. The group would choose a topic for study. This might be a disease entity, a procedure, a treatment or investigation. The topic should be one of general interest and should occur frequently enough in the type of practice being examined for a large enough number of records to be found.

The Medical Audit Committee would develop criteria and set standards for the topic. These should be the essential items in the diagnosis, admission or treatment, should probably not number more than 20 and should be clearly defined, and capable of being answered with a yes-no response. Acceptable exceptions to the criteria should be listed.

The Medical Audit Committee might develop its own criteria or adopt those prepared by outside sources, modifying these to best reflect local conditions. The participation of an outside specialist in the topic being discussed might be helpful. All participating physicians would be made aware of the criteria prior to the commencement of the audit.

The H.R.A. would develop a work sheet for the examination of each chart. Since in small hospitals, the person responsible for medical records may have only on-the-job training, the H.R.A. would need to provide an intensive education program in the form of workshops and training within the individual departments.

The work sheets would be returned to the H.R.A. for analysis and presentation to the Committee. It is the Medical Audit Committee's job, then, to evaluate the information and prepare a concise narrative report for distribution to the participating doctors and

hospitals. The Medical Audit Committee might also mount educational programs suggested by audit results with the assistance of outside specialists or make specific recommendations to doctors or hospitals.

The traditional Medical Audit Committee operates as a sub-committee of the organized medical staff of the hospital. This relationship has proven to be conducive to fostering a mutual interest in peer review and provides some mechanism for the implementation of recommendations. The success of a small or limited medical audit program is dependent upon a very high degree of personal commitment from the participating doctors to reinforce the loss of cohesion which is present in a larger medical staff organization.

If a small or limited number of physicians wished to start a Medical Audit Program as a pilot project they might approach the Department of Health for funds which could include the following:

1. Health Record Analyst salary - Since it could be anticipated that this analyst could supervise several audit programs, the services of a regional H.R.A. might be purchased.

2. Participating hospitals would request additional medical records staff time. In the initial phases of the project, when a good deal of time would be spent in attending workshops or learning terminology, this request might be justified. However, in an ongoing program, the number of charts each person would abstract would not be great, since the total number of charts for each audit might be only 30.

3. Time and travel for specialist physician consultants for criteria setting and education sessions - This amount would depend on the location of the region in relation to base centres, the type of audits being done, and the extent to which the participants wish to depend on published sources, outside specialists, or criteria established by the group.

4. Time and travel for Committee members - In a single hospital setting, Committee work is an obligation arising from the holding of staff privileges. In a group arrangement, there is less justification for considering this as unpaid time, and travel costs become a significant factor.

MODEL CONSENT FORM TO OPERATION & ANAESTHESIA

(Teaching Hospital)

I, _____, hereby authorize Dr. _____, a member of the medical staff of _____ Hospital, and/or such assistants as may be selected by him, to perform upon _____ the following operation procedure: _____

The anticipated procedure(s) have been explained by Dr. _____ or his assistant _____ and I understand the nature of the procedure(s). I acknowledge that no guarantee can be given as to the results of the operation or procedure(s).

I also consent to the administration of such anaesthetic as may be considered advisable, to be administered by or under the supervision of a member of the medical staff having privileges in anaesthesia, with the exception of the following types of anaesthesia: _____.
eg. "none", "spinal", etc.

I recognize that during the course of the operative procedure(s) unforeseen conditions may necessitate further extended, or alternative operative or diagnostic measures than outlined above. I therefore further authorize the above named physician and/or his designees to perform such procedures as are necessary in his professional judgement.

I also consent to the retention, for the purpose of study and diagnosis of any tissue that may be removed during the operative procedure.

I understand that this is a teaching hospital and that my physician may allow students to participate in the performance of the procedure(s).

Given this _____ day of _____, 19___, at _____ hours.

_____
Signature of Witness

_____
Signature of Patient (or of legal representative in the case of a minor or of a patient who is unable to sign by reason of mental or physical disability).

_____
Print Name of Witness

I confirm that I have explained the nature and effect of the procedure(s) to the patient or to the person consenting on behalf of the patient.

Dated this _____ day of _____, 19___, at _____ hours.

_____
Signature of Physician

APPENDIX J

MODEL CONSENT FORM TO OPERATION & ANAESTHESIA

(Non-Teaching Hospital)

I, _____, hereby authorize Dr. _____, a member of the medical staff of _____ Hospital, and whomever he may designate as his assistants to perform upon _____ the following operative procedure: _____.

The anticipated procedure(s) and the effect of such procedure(s) have been explained to me by Dr. _____ and I understand the nature of the procedure(s). I acknowledge that no guarantee can be given as to the results of the operative procedure(s).

I also consent to the administration of such anaesthetic as may be considered advisable by the physician responsible for this service, with the exception of _____.
eg. "none", "spinal", etc.

I also consent to such further or alternative procedure as may be found necessary during the course of the operative procedure.

I also consent to the retention, for the purpose of study and diagnosis, of any tissue that may be removed during the operative procedure.

Given this _____ day of _____, 19___, at _____ hours.

_____
Signature of Witness

_____
Signature of Patient (or of legal representative in the case of a minor or of a patient who is unable to sign by reason of mental or physical disability).

_____
Print Name of Witness

I confirm that I have explained the nature and effect of the procedure(s) to the patient or to the person consenting on behalf of the patient.

Dated this _____ day of _____, 19 ___, at _____ hours.